Mind & Peace Connection Center

Asim Rana MD PC

103 John Robert Thomas Drive, Exton, PA 19341-2652

Phone 484-879-6173 Fax 484-879-6176

INFORMED CONSENT FOR MEDICATION

Name:_____Date:_____MR#_____

Your psychiatrist has recommended the use of medication to address your mental health symptoms. Please read the following statement. Your signature below indicates that you have read the following and have had the opportunity to discuss your concerns or questions with your psychiatrist.

1. I have been educated about the prescribed medication. I have been informed of the advantages, disadvantages, side effects and alternatives to this medication. I understand that taking this medication is strictly voluntary.

2. I have had the opportunity to discuss the proposed treatment with my psychiatrist and have had the opportunity to have any questions answered to my satisfaction.

3. I understand that my psychiatrist believes that this medication is likely to help me, but is unable to give a guarantee of its effectiveness.

4. I understand that all medicine come with a risk of side effects and some side effects are rare, unpredictable and potentially harmful or deadly.

5. I understand that medicines can have an adverse effect on pregnancy and that all efforts should be made to avoid pregnancy during medication treatment. Should l become pregnant while on medicine, I understand I must contact my psychiatrist immediately to discuss the potential risks to myself, the pregnancy and the baby. I also understand that obstetricians should be informed that you have been on medications

6. I understand that I should inform the doctor or contact the office staff if there are any problems, reactions, and /or changes in my condition which may be related to this medication.

7. I understand that any written patient information available through this office is selective for its use as an educational aid and does not cover all the possible uses, actions, precautions, side effects, or interactions with this medication. It is not intended as medical advice for individual problems.

8. Some medications require periodic lab work to monitor blood levels or / to screen for possible negative effects on major organ systems of the body. Once ordered it is my responsibility to follow through on getting the ordered blood work complete. Failure to do so could potentially put me at risk for harm.

9. I understand that this consent allows other psychiatrist working in coordination with Dr. Rana to prescribe medications as clinically indicates if Dr. Rana is not available.

_____ _____

Psychiatrist Signature_____Patient and/or Parent Signature for minor.